

9821

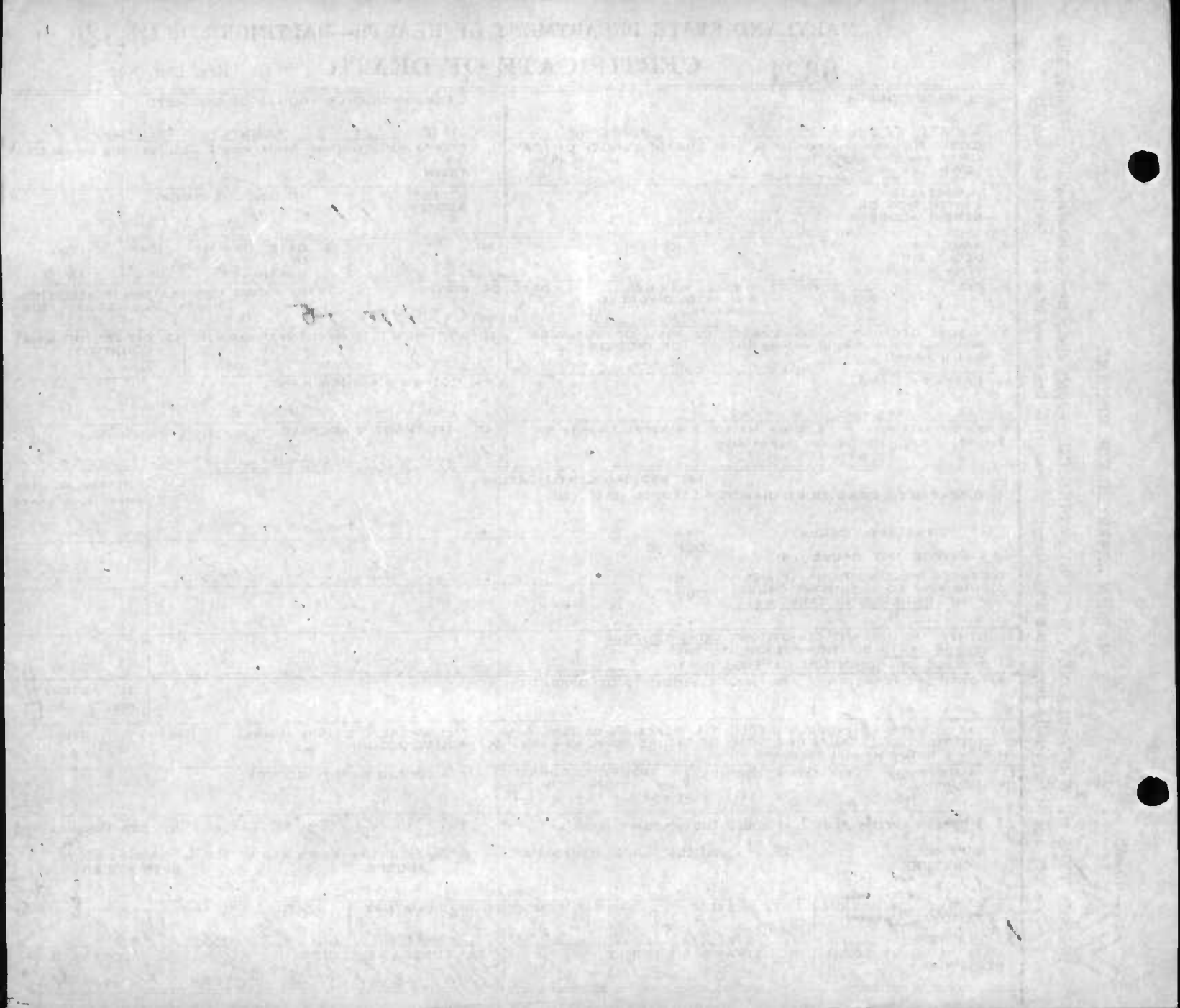
CERTIFICATE OF DEATH

Reg. Dist. No. 190.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Elkridge</u>	<u>Life</u>	OR TOWN <u>Elkridge</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5506 Race Rd</u>	STREET ADDRESS (If rural give location) <u>5506 Race Rd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mollie Belle Fletcher</u>		DATE: <u>Oct 20</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 30 1910</u> 45 yrs.
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Elkridge Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Alexander Myers</u>	
14. MOTHER'S MAIDEN NAME: <u>Ellen Texas Holland</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mary Fletcher Stewart</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>214X</u>			
ANTECEDENT CAUSE (S):		(A) <u>acute coronary occlusion</u> <u>1/2 hr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Chronic Bronchial Asthma</u> <u>29 yrs</u>	
		(C) <u>intermittent febrile</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Menorrhagia</u> <u>5 days</u>	
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/20/1955</u> , to <u>10/20/1955</u> , that I last saw the deceased alive on <u>10/20/1955</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.			
SIGNATURE <u>W.B. Brumblough</u>		M. D. <u>1609 Main St. Elkridge</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Burial</u>		<u>Oct. 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Arbutus Memorial</u>		<u>Arbutus Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>11-55</u>		<u>W. B. Brumblough</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Mrs. John R. Williams</u>		<u>P. Schorck</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 191

9822

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X <u>Rural ELlicott City</u>	<u>1 year</u>	<u>ELKridge</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Montgomery Road</u>		<u>12 Hunt Club Road</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>Oct. 8, 1955</u>	
<u>FLORENCE E. GRAVES</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>FEMALE</u>	<u>White</u>	<u>Widowed</u>	<u>6-16-88</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>67 yrs.</u>		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housewife</u>		<u>Domestic</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Edward Goslee</u>		<u>Elizabeth Hearn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u> <u>None</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Miss Doris Pehnert 12 Hunt Club Rd.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE			
<u>170X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) DUE TO			
<u>Coronary heart</u>			
(B) DUE TO			
<u>with mitral valve</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan, 1953</u> , to <u>Oct 8, 1955</u> , that I last saw the deceased alive on <u>Oct 7, 1955</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>John B. Loughman</u>		<u>10/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>MEADOWRIDGE MEMORIAL</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>Oct. 13, 1955</u>		<u>Howard County Md.</u>	
REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR	
<u>John B. Loughman</u>		<u>George L. Schrab</u>	
ADDRESS		ADDRESS	
<u>M. D. 10374 Calvert St - Baltimore</u>		<u>2101 Thudwick Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Leon Hochman
1037 N. Calvert St.

BUREAU V. S.

OCT 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9621

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09624

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH - COUNTY <u>Sykesville R 70</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Sykesville Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural West Friendship</u> LENGTH OF STAY <u>1 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Friendship Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>BETTIE</u> (First) <u>ELIZABETH</u> (Middle) <u>GROOMS</u> (Last)		4. DATE OF DEATH <u>October 26</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1881</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Somewell</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cooking</u>	9. AGE last birthday <u>74</u> yrs. If under 1 year: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James Cook</u>		14. MOTHER'S MAIDEN NAME <u>Carroll Better Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs Florence Howard</u> <u>Sykesville Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>Cardiac Disease with Dropsy</u>			<u>2 1/2</u>
(b) <u>Antecedent cause(s)</u> <u>Pneumonia</u>			
(c) <u>Other</u> <u>Sky perturbation</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Isaiah</u>			
19a. DATE OF OPERATION <u>May 5 1948</u>	19b. MAJOR FINDINGS OF OPERATION <u>Removal of breast malignancy</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/7</u> 19 <u>48</u> , to <u>Oct 26</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 25</u> 19 <u>55</u> , and that death occurred at <u>5:00</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Thos W. Walbridge M.D.</u> (Degree or title)		DATE SIGNED <u>Oct 27 1955</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>10-30-55</u>	NAME OF CEMETERY OR CREMATORY <u>Johnsville</u>	LOCATION (City, town, or county) (State) <u>Carroll County, Md.</u>
DATE REC'D BY LOCAL REG. <u>10-29-55</u>	REGISTRAR'S SIGNATURE <u>Mari G. Whitaker</u>	24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> <u>Rockville Md.</u>	

BUREAU V. 2

NOV 1 1955

RECEIVED

9823

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore Howard	MARYLAND	STATE Md.	COUNTY Balto
CITY (if outside corporate limits, write RURAL OR and give nearest town) TOWN Ellicott City	LENGTH OF STAY (in this place)	CITY (if outside corporate limits, write RURAL and give nearest town) TOWN Balto.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home	STREET ADDRESS (If rural give location) 5810 Winner Ave.		
3. NAME OF DECEASED: (First) WILLIAM (Middle) K. (Last) HOOPER		4. DATE (Month) (Day) (Year) OF DEATH: Oct. 2 19 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Aug. 16, 1869
9. AGE last birthday 86 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Agent (rtd)		10B. KIND OF BUSINESS OR INDUSTRY: Insurance	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: unknown	
14. MOTHER'S MAIDEN NAME: Adeline Kennard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS: Mr. Wm. D. Hooper-5810 Winner Ave.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cardiac failure			48 hrs
ANTECEDENT CAUSE (B) Hypertension arteriosclerotic			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) CO D			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. pneumonia			48 hrs
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 2, 1955 to Oct 2, 1955 that I last saw the deceased alive on Oct 2, 1955 , and that death occurred at 5:30 P. M. from the causes and on the date stated above			
SIGNATURE Joseph C. Matheis		ADDRESS 400 x Liberty St Balto Md	
DATE SIGNED Oct 3, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/5/55	NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.
LOCATION (City, town, or county) (State) Balto., Md.			
DATE REC'D BY LOCAL REGISTRAR 10-5-55		REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Wm. J. Lickner & Sons
		ADDRESS Balto Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WYOMING

1900

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09831

9824

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH- COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>WOODBINE</u> LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>10X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WEITZEL NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>SIDNEY</u>	(Last) <u>KIMMEL</u>
4. DATE OF DEATH	(Month) <u>October</u>	(Day) <u>4</u>	(Year) <u>1955</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>AUG 12-1870</u>
9. AGE last birthday <u>85</u> yrs.		If under 1 year 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANTHONY Z. KIMMEL</u>		14. MOTHER'S MAIDEN NAME <u>MARY MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY No. <u>—</u>	
(If year, give war or dates of service) <u>—</u>		17. INFORMANT AND ADDRESS <u>MRS MARY ELLEN ZAHTZINGER</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>Immediate cause <u>450.0</u> (a) <u>Generalized arteriosclerosis</u></p> <p>Antecedent cause(s) <u>—</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>—</u></p> <p>(c) <u>—</u></p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February, 1955, to October, 1955, that I last saw the deceased alive on Oct 3, 1955, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE W.B. Culwell, M.D. ADDRESS mt. airy md. DATE SIGNED October 4, 1955

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Oct 6-1955</u>	<u>CENTRAL CEMETERY</u>	<u>NEW LODDON MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Oct 6-1955</u>	<u>Lucian K Talcom</u>	<u>W. E. Falconer</u>	<u>700 Market Mtg</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09833

9825

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND CITY (if outside corporate limits, write RURAL and give nearest town) <u>Highland</u> OR TOWN <u>Highland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Simons Rest Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (if outside corporate limits, write RURAL and give nearest town) <u>Jessups</u> (Rural) OR TOWN <u>Jessups</u> STREET ADDRESS (If rural, give location) <u>Berger Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Blanche L. Moore</u>	4. DATE OF DEATH <u>Oct. 16, 1955</u>	5. DATE OF BIRTH <u>3-12-1884</u>	
6. SEX <u>Female</u>	7. COLOR OR RACE <u>White</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	9. AGE last birthday <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
13. FATHER'S NAME <u>Thomas Parlett</u>		14. MOTHER'S MAIDEN NAME <u>Grace Gosnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Laurence Moore, Jessups, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> Immediate cause (a) <u>Myocardial Failure</u> Antecedent cause(s) (b) <u>Hypertensive Cardio-Vasc. Dis.</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>903.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>10 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fract. L. Femur</u>			<u>5 weeks</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>accident</u> SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u> INJURY	(CITY OR TOWN) <u>Jessups</u> (COUNTY) <u>Howard</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 26 51' 3A</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell in bathroom</u>	
22. I hereby certify that I attended the deceased from <u>10/19</u> , 19 <u>55</u> , to <u>10/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>55</u> , and that death occurred at <u>7A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. M. Warren M.D.</u> (Degree or title)		ADDRESS <u>Laurel, Md.</u> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>10-19-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>	LOCATION (City, town, or county) (State) <u>Clarksville, Md</u>
DATE REC'D BY LOCAL REG. <u>10-20-55</u>	REGISTRAR'S SIGNATURE <u>Marie C. Whitaker</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u> ADDRESS <u>Ellicott City, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

OCT 24 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9826				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				00834.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								No. 194			
1. PLACE OF DEATH:								2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Howard				MARYLAND				STATE Md. COUNTY Howard			
CITY (If outside corporate limits, write RURAL OR and give nearest town)				LENGTH OF STAY (in this place)				CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN Clarksville								TOWN Clarksville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS								STREET ADDRESS (If rural, give location)			
100 Nichols Drive								Nichols Drive			
3. NAME OF DECEASED:								4. DATE OF DEATH			
(First) (Middle) (Last)								(Month) (Day) (Year)			
(Type or Print) ANTHONY CONNELL WILSON								Oct. 19 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday:		IF UNDER 1 YEAR	
Male		Colored		Single		Aug. 7, 1955		yrs. 2 Months 12 Days 12 Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None				10b. KIND OF BUSINESS OR INDUSTRY: None				11. BIRTHPLACE (State or foreign country): Olney, Maryland			
12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME: Walter Wilson				14. MOTHER'S MAIDEN NAME: Clarice Doye							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.: None				17. INFORMANT & ADDRESS: Shirley Smith, Clarksville, Maryland			
18. MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:											
525X Immediate cause (a) Interstitital pneumonia DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY				21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? Partial			
22. I hereby certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE William Wilson				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/19/55				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial				DATE THEREOF 10-21-55				NAME OF CEMETERY OR CREMATORY Hopkins Chapel			
LOCATION (City, town, or county) (State) Highland, Md				24. FUNERAL DIRECTOR F.C. Higinbotham, Baltimore City, Md.				ADDRESS			
DATE REC'D BY LOCAL REG. 10-20-55				REGISTRAR'S SIGNATURE Mario G. Whitaker							

2085212414

RECEIVED
OCT 24 1955
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore, 23.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Johns Lane</u>				STREET ADDRESS (If rural, give location) <u>2312 Frederick Ave.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>JAYES</u> (Middle) <u>ROSS</u> (Last) <u>WINSLOW</u>				(Month) <u>October</u> (Day) <u>5</u> (Year) <u>19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>April 9, 1902</u>	
				9. AGE last birthday: <u>53</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if <u>weather stripping</u>)		10b. KIND OF BUSINESS OR INDUSTRY: <u>Building</u>		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Hiram Winslow</u>				14. MOTHER'S MAIDEN NAME: <u>Orena Vailette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>unknown</u>				16. SOCIAL SECURITY No.: <u>?</u>		17. INFORMANT & ADDRESS: <u>Ferdinane DeBoy 5717 Mineral Ave, Haletrone, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
443x Immediate cause	(a) Cerebral Hemorrhage DUE TO	20 minutes	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Hypertensive Cardio Vascular disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE George E. Bungart Ellicott City, Md.	M. D.	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	DATE SIGNED 10-5-55
23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION	DATE THEREOF 10-8-55	NAME OF CEMETERY OR CREMATORY Loudon Park	LOCATION (City, town, or county) (State) BALTIMORE, Md.
DATE REC'D BY LOCAL REG. 10-2-55	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR George E. Schubert 2101 Frederick Ave. Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Name		Address	
City		State	
Occupation			
Date of Birth			
Sex			
Race			
Education			
Marital Status			
Religion			
Political Party			
Social Security Number			
Fingerprints			
Photograph			
Signature			
Date			
Agent			
Special Agent			
Supervisor			
Director			
Assistant Director			
Chief of Bureau			
Special Agent in Charge			
Assistant Special Agent in Charge			
Chief of Division			
Assistant Chief of Division			
Chief of Section			
Assistant Chief of Section			
Chief of Unit			
Assistant Chief of Unit			
Chief of Detail			
Assistant Chief of Detail			
Chief of Office			
Assistant Chief of Office			
Chief of Staff			
Assistant Chief of Staff			
Chief of Administration			
Assistant Chief of Administration			
Chief of Finance			
Assistant Chief of Finance			
Chief of Legal			
Assistant Chief of Legal			
Chief of Training			
Assistant Chief of Training			
Chief of Public Relations			
Assistant Chief of Public Relations			
Chief of Information			
Assistant Chief of Information			
Chief of Security			
Assistant Chief of Security			
Chief of Investigation			
Assistant Chief of Investigation			
Chief of Criminal			
Assistant Chief of Criminal			
Chief of Civil			
Assistant Chief of Civil			
Chief of Administrative			
Assistant Chief of Administrative			
Chief of Liaison			
Assistant Chief of Liaison			
Chief of Records			
Assistant Chief of Records			
Chief of Communications			
Assistant Chief of Communications			
Chief of Planning			
Assistant Chief of Planning			
Chief of Evaluation			
Assistant Chief of Evaluation			
Chief of Research			
Assistant Chief of Research			
Chief of Development			
Assistant Chief of Development			
Chief of Innovation			
Assistant Chief of Innovation			
Chief of Future			
Assistant Chief of Future			